CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DDIG	00	COMPLETED		
		15G606	A. BUILDING		03/02/2012		
		.0000	B. WING		00/02/2012		
NAME OF E	PROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
I WHILE OF I	NO VIDER OR SOLVEIL		3025 G	REENHILLS LN S			
REM-IND	DIANA INC		INDIANAPOLIS, IN 46222				
				,			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
W0000							
		0 1	W0000				
	This visit was to	or a fundamental	W 0000				
	recertification as	nd state licensure survey.					
		or the investigation of					
		•					
	complaint #IN0	0103651.					
	These surveys w	vere done in conjunction					
	1	·					
	_	rtification visit (PCR) to					
	the investigation	n of complaint					
	#IN00098375 co	ompleted on 10/31/2011.					
		p					
	Complaint #IN0	00103651: Substantiated,					
	no deficiencies	related to the allegations					
	are cited.	2					
	are cited.						
	Survey dates: F	February 27, 28, 29, 2012,					
	and March 1, 2,	2012					
	and march 1, 2,	2012					
	Facility Number	r: 001175					
	Provider Number	er: 15G606					
	AIM Number:						
	Allyl Nullibel.	100243040					
	Survey Team: I	Brenda Nunan, RN,					
	CDDN, PHNS I						
		111					
	These deficience	ies reflect state findings in					
	accordance with	· ·					
	accordance with	. 100 11 10 7 .					
	Quality review	completed on March 15,					
	2012 by Dotty V	Walton, Medical Surveyor					
	III.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CO A. BUILDING B. WING	00		TE SURVEY MPLETED 02/2012	
NAME OF PI	rovider or suppliei IANA INC	R	STREET A 3025 GI INDIAN	P CODE	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL STATE LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/02/2012		
	PROVIDER OR SUPPLIER		<u>.</u>	3025 G	ADDRESS, CITY, STATE, ZIP CODE FREENHILLS LN S IAPOLIS, IN 46222	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0104	policy, budget, a the facility. Based on record governing body policy and operathe client's availate exceed the \$1500 clients (client D) Findings include Client D's finance on 02/28/2012 at February 2012 Fthe client had no The "Account Quarasactions indiction of \$2102.00 which maximum allows account had been amount since 06/200 During an interval:20 p.m., the QID Developmental I stated "Client Dicertificate. We cauntil we get that the highest allow \$1500.00	review and interview, the failed to exercise general ting direction to ensure able money did not 0 limit for 1 of 4 sampled 10:41 a.m. The inance Ledger indicated COH (cash on hand). Lick Report" of client D's cated an account balance ch was over the able of \$1500.00. The nover the allowable 101/2011.	W0	104	The Program Director and Home Manager will be retrained on Client Finances, including ensuring that the client is not over resources at any time. All financial transactions are monitored by the Home Manager, reconciled on a monthly basis by the Program Director, and then reviewed by the Client Finance Specialist at the completion of each month. Once a month the Client Finance Specialist will notify the Area Director of all clients, if any, that are over resources, so that the Area Director can follow up on the plan of correction. Ongoing, the Area Director will complete quarterly reviews of a random sample of client finances to ensure that all is completely accurately and correctly. Completion Date: April 1, 2012 Responsible Party: Home Manager, Program Director, Client Finance Specialist, and Area Director.	e e of	04/01/2012

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		A. BUILDING B. WING	00	03/02	LETED 2/2012		
REM-IND	PROVIDER OR SUPPLIER DIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE		
		cial Worker indicated lient D's birth certificate						

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Event ID: JVSL11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		15G606	B. WIN			03/02/	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0112	information conta regardless of the the records.	keep confidential all ained in the clients' records, form or storage method of ation and interview, the	W0	112	The Program Director and Home		04/01/2012
		ensure confidentiality of			Manager will be retrained on		
	1	•			confidentiality per Indiana MENTOR		
	^	lth information for 4 of 4			and HIPPA regulations.		
	_	and 4 additional clients			All historical files containing		
	by storing clients	s' records in an unlocked			confidential client information will		
	room (clients A,	B, C, D, E, F, G, H).			be stored in a locked up area of the		
	Findings include	:			group home. Access to these files will be strictly prohibited to only those on a need to know basis determined by Indiana MENTOR, the		
	During observati	on on 02/27/2012 at 4:35			client, or guardian.	ŧ	
	p.m., additional of	client G entered his			Ongoing, the Area Director will		
	bedroom by walk	king through an unlocked			complete quarterly (or more) visits		
	1	where clients A's, B's,			to the group home to ensure that al	ı	
		G's, and H's "Historical			confidential information is correctly		
		d on the floor in boxes			stored in the home.		
		r names. "Historical			Completion Date: April 1, 2012		
					Responsible Party: Home Manager,		
		" were stored in boxes on			Program Director, and Area Director		
	a coffee table.						
	4:35 p.m., the Ho	iew on 02/27/2012 at ouse Manager stated 'bother anything" in the ated the boxes contained formation.					
	1:15 p.m., Admir indicated client (iew on 02/29/2012 at nistrative Staff #1 G can read. She indicated nould have been stored in					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CO A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER DIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	a secured location	n.						
	a secured location 9-3-1(a)	on.						

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Facility ID: 001175

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		15G606	B. WIN			03/02/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R			REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0140	483.420(b)(1)(i)	NES.					
	CLIENT FINANC	establish and maintain a					
	system that assures a full and complete accounting of clients' personal funds						
		facility on behalf of clients.					
	i	review and interview, the	W0	140	After an Investigation was		04/01/2012
		maintain a complete			completed, it was discovered that		
	l *	e clients' cash on hand at			the remaining change that was		
		for 3 of 4 sampled clients			missing for each individual was in		
	_ ^	•			the bottom of the cabinet where the	е	
		d C) and for 2 additional			finances are kept.		
	clients (clients F	and H),			The Program Director and Home		
	Findings include:				Manager will be retrained on Client Finances, including ensuring that the client's ledgers balance at all times.		
	1. Client A's fina	ancial records were			All financial transactions are		
		27/2012 at 3:50 p.m.			monitored by the Home Manager,		
		ary 2012 Finance Ledger			reconciled on a monthly basis by the Program Director, and then	2	
		ent had \$4.94 COH (cash			reviewed by the Client Finance		
		,			Specialist at the completion of each		
	· · · · · · · · · · · · · · · · · · ·	A had \$4.69 actual COH			month.		
	in her pocket fold	der.			Ongoing, the Area Director will		
					complete quarterly reviews of a		
	_	iew on 02/27/2012 at			random sample of client finances to		
		ouse Manager indicated			ensure that all is completely		
	he did not know	why client A's COH was			accurately and correctly.		
	off by 25 cents.				Completion Date: April 1, 2012		
					Responsible Party: Home Manager, Program Director, Client Finance		
	2. Client B's fina	ancial records were			Specialist, and Area Director.		
	reviewed on 02/2	27/2012 at 3:50 p.m.			Specialist, and Area Bilector.		
	Client B's Februa	ary 2012 Finance Ledger					
		ent had \$29.99 COH.					
		0.22 actual COH in her					
	pocket folder.						
	During an interv	iew on 02/27/2012 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G606		LDING	NSTRUCTION 00	(X3) DATE COMPI 03/02	ETED	
	PROVIDER OR SUPPLIER		3025 GF	.DDRESS, CITY, STATE, ZIP CODE REENHILLS LN S APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
		ouse Manager indicated why client B's COH was				
	reviewed on 02/2 Client C's Februa indicated the clie	ancial records were 27/2012 at 3:50 p.m. ary 2012 Finance Ledger ent had \$25.80 COH.				
	During an interview on 02/27/2012 at 3:50 p.m., the House Manager indicated he did not know why client C's COH was off by 70 cents.					
	reviewed on 02/2 Client F's Februa indicated the clie	ancial records were 27/2012 at 3:50 p.m. ary 2012 Finance Ledger ent had \$9.37 COH. 15 actual COH in his				
	3:50 p.m., the Ho	iew on 02/27/2012 at ouse Manager indicated why client F's COH was				
	reviewed on 02/2 Client H's Februa indicated the clie	ancial records were 27/2012 at 3:50 p.m. ary 2012 Finance Ledger ent had \$12.91 Client H al COH in her pocket				

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	OF CORRECTION OF CORRECTION 15G606	(X2) MULTIPLE CO A. BUILDING B. WING	00		LETED 2/2012		
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	During an interview on 02/27/2012 at 3:50 p.m., the House Manager indicated he did not know why client H's COH was off by 20 cents. 9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		15G606	B. WIN			03/02/	2012
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0248	483.440(c)(7) INDIVIDUAL PRIA A copy of each of be made availab including staff of with the client, and the client is a mine Based on interview facility failed to oprovider received (Individual Suppose (Behavioral Suppose Sampled clients) Findings include 1. Client #A's Vareviewed on 02/2 record did not incompose the record did not included an ISP, included an ISP, included in the record did not reviewed on 02/2 included in the record did not reviewed on 02/2 included in the record did not record di	dient's individual plan must le to all relevant staff, other agencies who work and to the client, parents (if nor) or legal guardian. It was and record review, the ensure the day service da current ISP ort Plan)/BSP port Plan) for 3 of 4 clients A, C, and D). Cocational Record was 27/2012 at 2:20 p.m. The clude a current ISP/BSP. Boord was dated as BSP in the record was 28/2012 at 9:38 a.m. and dated 12/01/2009 was ecord. A BSP, dated included in the record. Cational Record was 29/2012 at 10:00 a.m. ot include a current ISP.	W0	TAG 248	The Program Director will receive corrective action for not ensuring completion. The Program Director will send all Day Placements the current ISPs and BSPs for the common clients. The Program Director will be retrained on IDT's. The training will include who to part of the IDT, when to include the IDT, and to remember to ensure that all members of the IDT are kept up to date at all times. Ongoing, the Area Director will participate in at least one IDT meeting to ensure that the Program Director is including all IDT members when applicable. Ongoing, the Area Director will complete random Day Placement Audits/Observations to ensure that all have current information, including, but not limited to ISPs and BSPs for common clients. Completion Date: April 1, 2012 Responsible Party: Home Manager, Program Director, and Area Director	d d	04/01/2012
	reviewed on 02/2 included an ISP, included in the re 12/29/2011 was in 2. Client C's Voc reviewed on 02/2 The record did not be seen to be seen	28/2012 at 9:38 a.m. and dated 12/01/2009 was ecord. A BSP, dated included in the record. cational Record was 29/2012 at 10:00 a.m. ot include a current ISP.			complete random Day Placement Audits/Observations to ensure that all have current information, including, but not limited to ISPs and BSPs for common clients. Completion Date: April 1, 2012 Responsible Party: Home Manager,		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		15G606	A. BUI B. WIN	LDING		03/02/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	1			REENHILLS LN S		
REM-IND	DIANA INC			INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		y group home record was		TAG	DEFICIENCY)		DATE
	reviewed on 02/28/2012 at 1:02 p.m. The record included an ISP, dated						
	08/30/2011.	191 , u utou					
	3. Client D's Vo	cational Record was					
	reviewed on 02/2	29/2012 at 10:00 a.m.					
	The record did n	ot include a BSP.					
	ar . Di a iii						
		y group home record was 28/2012 at 11:07 a.m.					
		ded a BSP, dated					
	10/03/2011.	ueu a BSF, uaieu					
	10/03/2011.						
	During an interv	iew on 02/29/2012 at					
	_	nistrative staff #1					
		service providers should					
	have current ISP	_					
	9-3-4(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLI	ETED
		15G606		B. WING 03/02/2012			2012
NAME OF B	DOWNER OF CHIRD IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	-		3025 G	REENHILLS LN S		
	DIANA INC				IAPOLIS, IN 46222		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ГЕ	COMPLETION DATE
W0252		LSC IDENTIFYING INFORMATION)	+	TAG	BLI ICLAYCT)		DATE
WU252	criteria specified plan objectives n measurable term	accomplishment of the in client individual program nust be documented in as.					
	Based on intervio	ew and record review, the	W0	252	All staff were retrained on		04/01/2012
	facility failed to	ensure data collection at			completing training objectives		
	the recommende	d frequency for 16 of 25			correctly on 3-14-2012.		
	training program	s reviewed for			The Home Manager will complete two weekly observations to ensure		
	measurable skills	s improvement for 4 of 4			that all staff are completing the		
	sampled clients (clients A, B, C, and D).			objectives correctly with the clients.		
	Findings include			Along with the observations, the Home Manager will also complet weekly random documentation			
	Client A's record	was reviewed on			reviews to ensure that all staff are completing the documentation to		
	02/28/2012 at 9:3	38 a.m. Client A had 7			record the completion of the		
	ISP (Individual S	Support Plan) goals in			objectives.		
	which data was c	collected for measurable			The Program Director will review all		
	skill acquisition.	Cumulative data			documentation reviews and		
	_	provided for 01/2012 and			completed observations to ensure		
	12/2011, but indi	ividual data sheets were			that they are being completed		
	•	erify frequency of data			correctly by both the staff and the Home Manager.		
	collection.				Ongoing, the Area Director will		
					complete random quarterly audits		
	objective for idea weekly. A review was not collected 14, 15, 16, 18, 19. Refusals to comp documented on F 23, 2012.	1/09/2011, indicated an intifying coins three times we of data, indicated data on February 4, 5, 6, 13, 19, 20, 21, and 26, 2012. Solete the objective were February 9, 17, 22, and			to ensure that all documentation is being completed and correctly. Completion Date: April 1, 2012 Responsible Party: Home Manager, Program Director, and Area Director		
	An objective for	physical fitness indicated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G606	A. BUII	LDING	00	COMPL 03/02/	
		13G000	B. WIN			03/02/	2012
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S		
REM-IND	DIANA INC				APOLIS, IN 46222		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		have exercised 30 minutes		IAG	,		DATE
		kly. Review of data					
		ejective was not completed					
		5, 13, 14, 15, 16, 18, 19,					
		26, 2012. Refusals to					
		ejective were documented					
	•	2, 3, 6, 7, 8, 9, 10, 17, 22,					
	23, and 24, 201						
		ve for stating the reason					
	_	oro (antidepressant) was					
		February 3, 10, 11, 12, 17,					
	24, 25, and 26,	2012.					
	An objective fo	r wearing tennis shoes to					
		a week was not					
		ruary 3, 10, 17, 24,2012					
		•					
	2. Client B's re	cord was reviewed on					
		2:29 p.m. Client B had 5					
	_	ich data was collected for					
		l acquisition. Cumulative					
		was provided for 01/2012					
	•	at individual data sheets					
	•	led to verify frequency of					
	data collection.						
	An Individual S	Sunnort Plan (ISP) dated					
	An Individual Support Plan (ISP), dated 02/09/2012, indicated an objective for stating the reason she takes Effexor (antidepressant) daily. A review of data,						
		vas not collected on					
		11, 12, 17, 24, 25, 26,					
	2012.	, , , , -, ·•;					
	I		1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G606	A. BUILDING 00			COMPLETED	
13G000			B. WIN			03/02/2012	
NAME OF F	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REM-INDIANA INC			3025 GREENHILLS LN S INDIANAPOLIS, IN 46222				
					AFOLIS, IN 40222		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
1110	TEGOESTI ON ON			0		5.112	
	An objective for	filling out a model check					
		ek was not completed					
		4, 5, 6, 8, 9, 10, 11, 12,					
		, 19, 20, 21, 24, 25, 26,					
	2012.	, 17, 20, 21, 24, 25, 20,					
	2012.						
	An objective for	physical fitness indicated					
		nave exorcized 20					
		nes weekly. Review of					
		e objective was not					
		ary 1, 2, 3, 4, 5, 6, 9, 10,					
	_	0, 21, 25, 26, 2012.					
		plete the objective were					
	_						
	23 2012	February 8, 9, 15, 18, 19,					
	25 2012						
	2 Client C's rec	ord was reviewed on					
		02 p.m. Client C had 7					
		ch data was collected for					
	•	acquisition. Cumulative					
		was provided for 01/2012					
		t individual data sheets					
	· · · · · · · · · · · · · · · · · · ·	ed to verify frequency of					
	data collection.	to verify frequency of					
	data confection.						
	Δn Individual Si	apport Plan (ISP), dated					
		cated a daily objective					
	· ·	giene supplies for					
		view of data, indicated					
		lected on February 4, 5, 6,					
		• • • • • • • • • • • • • • • • • • • •					
	18, 19, 20, 2012.	•					
	Client C had an a	objective for identifying					
	Chem C hau all	objective for identifying					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				ETED	
		15G606	B. WIN			03/02/	2012	
			1		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	ę.		3025 GREENHILLS LN S				
	DIANA INC			INDIAN	APOLIS, IN 46222			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE	
		s weekly. A review of						
	· ·	ata was not collected on						
		7, 11, 12, 13, 14, 17, 18,						
	19, 20, 21, 25, 20	6, 2012.						
	, ,	e for thoroughly washing						
	with personal wa	ashcloth was not						
	completed Febru	nary 4, 5, 6, 18, 19, 20,						
	2012.							
	An objective for	setting the oven						
	temperature thre	e times weekly was not						
	completed Febru	nary 1, 2, 3, 4, 5, 7, 8, 9,						
	_	6, 17, 18, 19, 20, 21, 22,						
	23, 24, 2012.							
	, , , .							
	An objective for	exercising 30 minutes						
	1	k was not completed						
		4, 5, 9, 10, 11, 12, 13,						
	17, 18, 19, 20, 20							
	1, 10, 17, 20, 2	V12.						
	4 Client D's rec	cord was reviewed on						
		:07 a.m. Client D had 6						
	`	Support Plan) goals in						
		collected for measurable						
		Cumulative data						
		provided for 01/2012 and						
	12/2011, but individual data sheets were not provided to verify frequency of data							
	collection.							
	An Individual Su	upport Plan (ISP), dated						
	10/03/2011, indi	cated an objective for						
	preparing part of	f morning, noon or						

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	OF CORRECTION IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/02/2012				
	PROVIDER OR SUPPLIER DIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE				
IAU	evening meal three times per week. A review of data, indicated data was not collected on February 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 23, 24, 25, 2012. An objective for brushing teeth twice daily was not completed in the a.m. on February 3, 7, 16, 19, 24, 25, 2012. A review of data indicated the objective was not completed during the p.m. on February 1, 2, 3, 4, 5, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 2012. An objective for participating in an activity of his choice with housemates twice weekly was not completed on February 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 23, 24, 25, 2012. During an interview on 02/29/2012 at 1:50 p.m., Administrative Staff #1 indicated the programs should have been implemented at the frequency listed on the program plan. 9-3-4(a)							

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G606		ĺ	LDING	00	(X3) DATE COMPL 03/02/	ETED	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				3025 G	ADDRESS, CITY, STATE, ZIP CODE REENHILLS LN S IAPOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0382	The facility must biologicals locked prepared for adm Based on observations facility failed to locked when una additional client while the medical dining room table. Findings include During medication observations on ODSP #1 left client (antifungal crean Desmopressin (namount of urine 10.01% on the dinunattended for 3 medications to clithrough the room medications were discovered buring an intervity 7:45 a.m., DSP # have returned the locked cabinet with from the table. During an intervity 1:50 p.m., Administrations medications medications were discovered to the locked cabinet with locked cabinet	ation and interview, the ensure medications were ttended by staff while 1 (G) was in the room ations were left on the e. En administration 02/28/2012 at 6:35 a.m. at E's Econazole (a) Cream 1% and (a) nedication to reduce the produced) Nasal Spraying room table minutes between passing tients. Client G walked (a) where the unsupervised	W0	382	All direct care staff were retrained on Medication Administration including Medication Security, and Passing Meds with Privacy on 3-14-2012. Ongoing, the Home Manager and/or Program Director will complete 2 weekly Medication Administration Observations to ensure that all staff are passing meds correctly. All observations will be reviewed by a supervisor for completion and accuracy. Completion Date: April 1, 2012 Responsible Party: Home Manager, Program Director, and Area Director.	f	04/01/2012

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G606		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 03/02/	ETED		
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG		tended and unsecured.		TAG	DEFICIENCY)	ALE.	DATE	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
		15G606	B. WING			03/02/	2012	
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				REENHILLS LN S			
REM-IND	REM-INDIANA INC			INDIANAPOLIS, IN 46222				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0440	least quarterly fo	hold evacuation drills at reach shift of personnel.	W10	4.40			04/01/2010	
	Based on record	review and interview, the	W0	440	All Direct Support Professionals will		04/01/2012	
	facility failed to	ensure an evacuation drill			receive a retraining every other			
	was conducted qu	uarterly for each shift for			month to ensure that they			
		lients and 4 additional			understand the importance of			
	•	, B, C, D, E, F, G, and			completing the monthly fire drills. The retraining will include reviewing			
	Н).	, , -, , , , -,			a copy of the Fire Drill Schedule.			
	Findings include	:			Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure			
	The facility's eva	cuation drills were			that the health and safety of the			
	reviewed on 02/2	27/2012 at 12:50 p.m.			client's needs are met.			
	Records indicate	d a drill was completed			Ongoing, all completed fire drill			
		ng shift on 12/9/2012 at			reports will be turned in to and			
	_	ecord did not include			reviewed by Quality Assurance for			
	•	indicate fire drills were			accuracy and thoroughness of each			
		g the day or night shift			drill.			
		er covering December			Completion Date: April 1, 2012			
	• •				Responsible Party: Home Manager			
	_	112 and February 2012.						
		d a drill was completed						
		shift on 03/08/2011 at						
		ring the evening shift on						
		32 p.m The record did						
		mentation to indicate a						
	fire drill was con	npleted during the day						
	shift during the q	uarter covering March,						
	April, and May 2	2011.						
	3:45 p.m., the Ho	iew on 02/27/2021 at ouse Manager indicated						
	all completed dri	lls were included in the						

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G606	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/02/2012			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 GREENHILLS LN S INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
TAG	record. During an interview on 02/28/2012 at 11:20 a.m., Administrative staff #1 indicated the drills should have been completed quarterly. 9-3-7(a)	TAG	DEPICIENCY	DATE			

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